Bureau of Quality Improvement Services (BQIS)

Incident Data and Recommendations

Incident Communication **10/01/2012 through 12/31/2012**

BQIS

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Communication Purpose

The Division of Disability and Rehabilitative Services (DDRS) Bureau of Quality Improvement Services (BQIS) utilizes an incident reporting and management system as an integral tool in ensuring the health and welfare of people receiving services from one of the Home and Community-Based Services (HCBS) waivers administered by the Bureau of Developmental Disabilities (BDDS). Effective 9/1/2012, the name of the previous Developmental Disability (DD) waiver changed to the Community Integration and Habilitation (CIH) waiver. In addition, the previous Support Services (SS) waiver changed to FSW (Family Supports Waiver). The data for the previous Autism (AUT) waiver will also be incorporated into the CIH waiver.

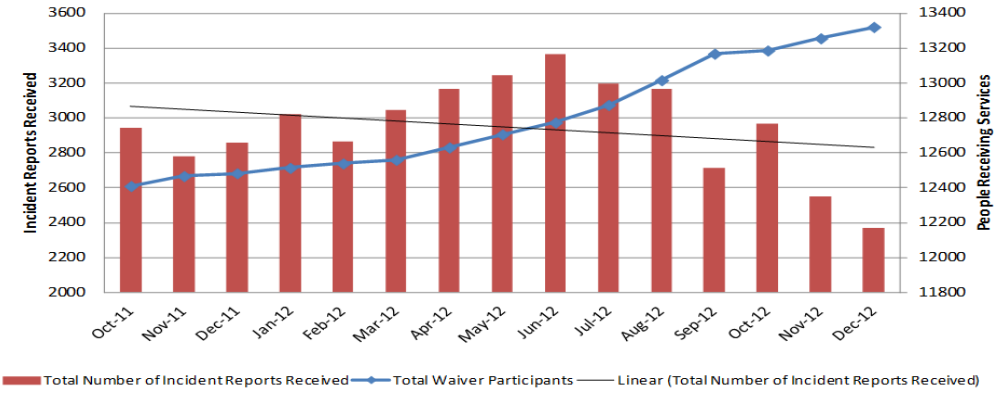
The criteria of a reportable incident can be found in the *DDRS Incident Reporting and Management Policy* located at http://www.in.gov/fssa/files/Incident_Reporting_and_Management.pdf. In addition, there is a webinar presentation and a Frequently Asked Questions (FAQs) document relative to Incident Reporting located on the BQIS website at http://www.in.gov/fssa/ddrs/3838.htm.

On a quarterly basis BQIS produces communications summarizing incident data, mortality data, and findings from complaint investigations and provider compliance reviews. Every issue presented in these communications is supported by data indicating the need for improvement. BQIS expects that providers will review this information, assess how the agency can best address the identified issues with their consumers and staff, and incorporate these new practices into its systems.

General Incident Data

While the number of initial incident reports submitted in October 2012 increased from September 2012, the months of November and December 2012 were both significantly lower than the monthly average of 2950 reversing the reportable incident volume trend line. One hypothesis for the lower numbers in November and December is an increased number of visits with family during the holidays. The pattern of fewer reported incidents in November and December (compared to the rest of the months in the same calendar year) has been present during the last three years (2010-2012). Reviewing the data by quarter instead of by month shows the lowest number of reports (7887) submitted in 2Q FY13 (October-December 2012) and the highest number of reports (9778) submitted in 4Q FY12 (April-June 2012) with a variation of 1891 between the high and low quarters.

Figure 1. Reportable Incident Volume - Waiver



General Incident Data (cont.)

The number of people receiving services through one of the HCBS waivers is presented in Table 1 to be used as a frame of reference. As of October 2012, the data for people previously receiving services via the Autism waiver are now included in the CIH waiver data. The number of waiver participants continues to increase.

Table 1. Number of People Receiving Waiver Services.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
CIH Waiver	7195	7201	7203	7214	7227	7230	7223	7260	7830	7831	7839	7857
AUT Waiver	505	508	524	536	546	550	552	561	58	0	0	0
FS Waiver	4814	4830	4833	4881	4933	4994	5099	5195	5280	5355	5417	5464
Total Waiver Participants	12514	12539	12560	12631	12706	12774	12874	13016	13168	13186	13256	13321

Incident Processing

The timelines for incident processing include the provider/mandated reporter submitting an incident report (IR) through a Web-based application within 24 hours of initial discovery of a reportable incident. The incident report is processed to determine whether or not appropriate and sufficient actions to remedy the situation, prevent chances for recurrence, and to ensure the person's immediate safety have been taken. Based on this determination, the incident is either marked as closed or marked as additional follow-up is required. The incident reporting system automatically generates an e-mail to a designated distribution list to notify them whether or not a follow-up report is required. A follow-up report is required if immediate protective measures were not included in the initial incident report. The responsible person (per *DDRS Incident Management and Reporting Policy*), along with input from the support team, submits follow-up reports for incidents determined to need follow-up within seven days and every seven days thereafter until the incident is resolved to the satisfaction of all entities.

The data for the last three quarters for the number of incidents reported within time period was calculated using the date of knowledge instead of the date of incident. As noted in Table 2, this improves the percentage of incidents reported within 0-1 days; however, this also presents a bit of a lag in ensuring health/safety. It is essential that provider agencies and other interested stakeholders continue to be diligent with examining and modifying internal processes to work toward closing the gap between the date of the incident and the date of knowledge. Providers must also ensure that staff are knowledgeable of the incident reporting requirements.

Table 2. Number and Percentage of Incident Reports Reported within 24 Hours of Discovery for People Receiving Waiver Services.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Average
Total Number of Incident Reports Received	3021	2862	3048	3166	3244	3368	3195	3165	2712	2965	2554	2368	2972.3
Total Number of Incidents Reported within Time Period (0-1 days)	2282	2141	2277	2885	2929	3104	2940	2933	2538	2783	2290	2209	2609.2
Percentage Reported within Time Period (0-1 days)	75.54%	74.81%	74.70%	91.12%	90.29%	92.16%	92.02%	92.67%	93.58%	93.86%	89.66%	93.29%	87.78%

Incident Processing (cont.)

The percentage of incidents resolved within the stipulated time period for July and August 2012 are significantly lower (53.96% and 55.83% respectively). One of the variables that potentially contributed to this decrease is the fluctuation surrounding additional case management agencies as of 9/1/2012. A significant number of incident report e-mails sent out had an auto-reply that the case manager was on vacation or no longer employed. While the case management agency had e-mails forwarded internally, the volume could have pushed the resources to the limit. As seen in Table 3, the percentages for September through December have returned to previous levels.

Providers must remain vigilant in resolving (and documenting) incidents in a timely manner. Providing answers to the questions that were included in the *follow-up required* e-mail is important. For instance, if a person was hospitalized, include the discharge diagnoses and any discharge instructions that will prevent/reduce the likelihood of a recurrence; if there was a medication error, include whether there was any negative outcome as a result of the medication error and what steps have been taken to reduce the likelihood of additional medication errors; if there was a fall resulting in injury, include information on whether a fall prevention plan has been developed/revised and if staff have been trained/retrained on the plan; etc. Including information on how the agency/team will monitor to ensure a similar situation does not occur in the future provides information on the longer-term resolution/systemic action.

Table 3. Number and Percentage of Incident Reports Resolved within Stipulated Time Period for People Receiving Waiver Services.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Average
Total Number of Incident Reports Received	3021	2862	3048	3166	3244	3368	3195	3165	2712	2965	2554	2368	2972.3
Number of Incidents Requiring Follow-up	1911	288	1877	2025	1981	2047	1911	1976	1639	1755	1475	1417	1691.8
Total Number of Incidents Resolved	3020	2844	2868	3162	3191	3036	1929	1918	2254	2954	2503	2080	2646.5
Total Number of Incidents Resolved within Stipulated Time Period (30 days)	2836	2693	2822	2955	2994	3002	1724	1767	2251	2767	2391	2063	2522.0
Percentage of Incidents Resolved within Stipulated Time Period (30 days) (Resolved/Received)	93.88%	94.10%	92.59%	93.34%	92.29%	89.13%	53.96%	55.83%	83.00%	93.32%	93.62%	87.12%	84.85%

At the time the initial incident report is processed, the incident reviewer also evaluates if an incident meets the criteria of being a sentinel event. Sentinel events are situations where a person is/was at significant risk and immediate safety measures need to be in place. Allegations of abuse, neglect and exploitation are considered sentinel events. In addition, elopement when health and welfare are at risk, choking incidents requiring intervention, suicide attempts, arrests, alleged criminal activity by a person receiving services, significant injury/health risk, (e.g., fracture, etc.), and prohibited techniques (e.g., mechanical restraint for behavioral purposes, prone restraint, seclusion, use of aversive techniques) meet the criteria of a sentinel event. It is possible that additional incidents will be made sentinel based on the information provided (e.g., hospitalizations, fire, etc.).

In the event an incident is made sentinel, the case manager makes either face-to-face or phone contact with the provider within 24 hours of notification of the sentinel event. Sentinel status will remain unresolved until there is documentation in either the initial incident report or a follow-up report that appropriate action(s) was taken to resolve the issue. When documentation ensuring health and welfare is confirmed, the sentinel status is resolved.

The percentage of sentinel events resolved within three days for five of the past six months has been above the monthly average of 85.04%. Providers are reminded of the importance of ensuring immediate safety measures are taken. Depending on the nature of the incident, immediate safety measures can vary; however, some of the more common safety measures include suspending staff from duty pending the outcome of the investigation for an allegation of abuse, neglect or exploitation involving staff; taking action (e.g., developing/revising a choking prevention plan, retraining staff, providing closer supervision/monitoring at least for the short term, etc.) prior to the next time a person eats/takes medication in the event of a choking episode; and taking immediate action (e.g., staff training, revision of fall prevention plan, etc.) in the event of a fracture.

Incident Processing (cont.)

Table 4. Number and Percentage of Sentinel Events Resolved within Stipulated Time Period for People Receiving Waiver Services.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Average
Total Number of Sentinel Events	419	387	324	483	417	469	406	493	382	368	249	302	391.58
Total Number of Sentinel Events Resolved within Stipulated Time Period (3 days)	372	338	282	381	310	353	360	456	342	324	210	268	333.00
Percentage of Sentinel Events Resolved within Stipulated Time Period (3 days)	88.78%	87.34%	87.04%	78.88%	74.34%	75.27%	88.67%	92.49%	89.53%	88.04%	84.34%	88.74%	85.04%

Allegations of Abuse, Neglect, and Exploitation

The allegations of abuse, neglect, and exploitation included in Table 5 and Figure 2 are inclusive of the alleged perpetrator being a staff person, a family member/guardian, a community person, and in a small number of cases, a peer. There was a high of 194 allegations of neglect reported in April 2012. Even with the significantly lower number of reports of allegations of neglect in November 2012, this category continue to be the most frequently reported type of allegation accounting for 44.66% of the total number of allegations of abuse, neglect and exploitation reported from January 2012 through December 2012. The high and low number of reported allegations of exploitation occurred in April 2012 and November 2012 respectively.

Two additional coding options (alleged, suspected or actual individual rights violation and alleged, suspected or actual lack of consumer supports) were activated as of 11/1/2012.

Alleged, suspected, or actual violation of **individual rights**. Individual rights include but are not limited to:

(1) right to be free from unnecessary medications and restraints
(2) opportunity for personal privacy
(3) not compelled to perform services for a provider
(4) if an individual works voluntarily for a provider, the individual is compensated:
    (A) at the prevailing wage for the job; and
    (B) commensurate with the individual's abilities
(5) the opportunity to communicate, associate, and meet privately with persons of the individual's choosing
(6) the means to send and receive unopened mail;
(7) access to a telephone with privacy for incoming and outgoing local and long distance calls at the individual's expense
(8) opportunity to participate in social, religious, and community activities
(9) right to retain and use appropriate personal possessions and clothing
(10) protecting an individual's funds and property from misuse or misappropriation

Alleged, suspected, or actual lack of **consumer supports**. These include but are not limited to:

(1) Inadequate supervision
(2) Staff not available as designated in the Service Plan
(3) Staff not providing support activities as designated in the Service Plan

If any of the above situations impact or have the potential to impact health and safety, the incident will be coded as an allegation of neglect and the incident made sentinel.

To provide some additional insight, a couple of questions and answers follow.

Q. What is the difference between an allegation of neglect and a rights violation?
A. People with intellectual or developmental disabilities have the same rights as other citizens (e.g., right to be free from unnecessary

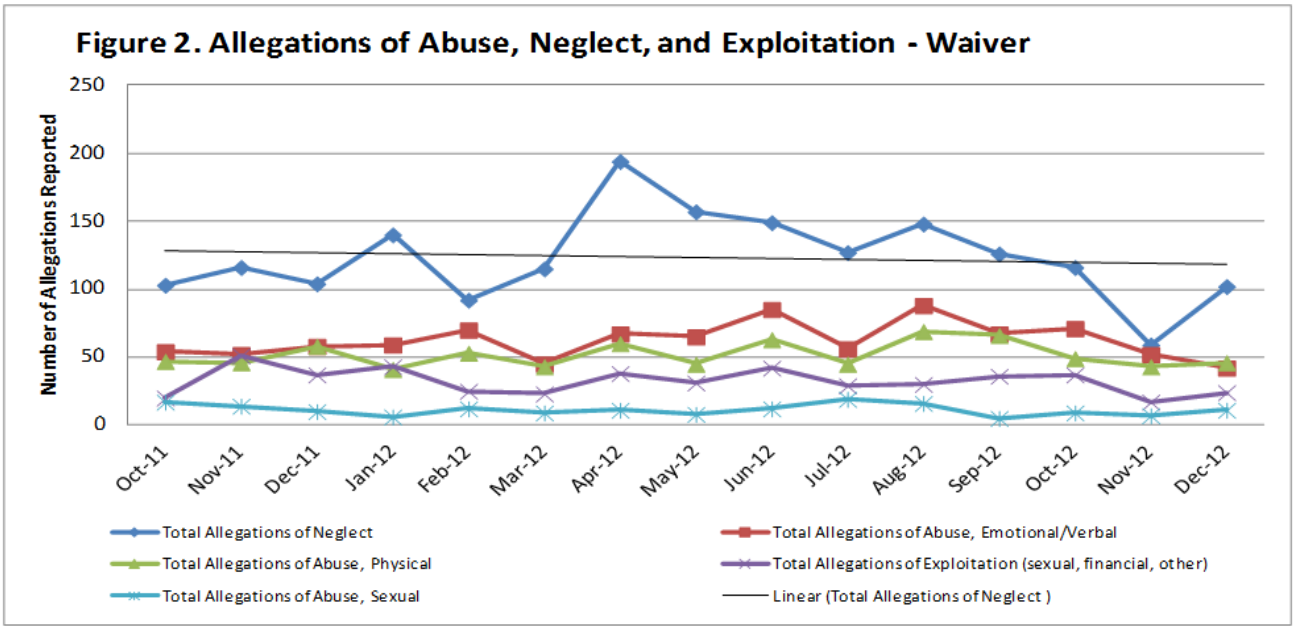
Allegations of Abuse, Neglect, and Exploitation (cont.)

medication and restraint, opportunity for compensation for work, personal privacy, opportunity to communicate, associate, and meet privately with people of the individual's choosing, the means to send and received unopened mail, opportunity to participate in social, religious, and community activities, access to a telephone with privacy for conversations, right to retain and use appropriate personal possessions and clothing, and protection from misuse of funds or property, etc.). Any restriction of these rights (i.e., rights violation) that impacts or have the potential to impact a person's **health and/or safety** will be coded as neglect and the incident made sentinel.

Q. What is the difference between an allegation of neglect and lack of consumer supports?
A. Consumer supports are provided to people in order to facilitate them meeting their needs (e.g., transportation) or in order to achieve their personal goals and objectives (outlined in the Service Plan). While both neglect and lack of consumer supports pertain to an absence of something, it only rises to the level of neglect if the absence impacts or has the potential to impact a person's **health and/or safety**.

Table 5. Allegations of Abuse, Neglect, and Exploitation Involving People Receiving Waiver Services.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Average
Total Allegations of	140	92	115	194	157	149	127	148	126	116	59	102	127.08
Total Allegations of Abuse, Emotional/ Verbal	59	70	45	67	65	85	56	88	67	71	52	42	63.92
Total Allegations of Abuse, Physical	41	53	43	60	45	63	45	69	66	49	43	46	51.92
Total Allegations of Exploitation (sexual, financial, other)	43	25	23	38	31	42	29	30	36	37	17	24	31.25
Total Allegations of	6	12	9	11	8	12	19	16	5	9	7	11	10.42
Grand Total	289	252	235	370	306	351	276	351	300	282	178	225	284.58



Allegations of Abuse, Neglect, and Exploitation (cont.)

The analysis of allegations of abuse, neglect, and exploitation since the implementation of the revised *DDRS Incident Reporting and Management Policy* on 3/1/2011 identified some issues. One of the issues was that the quality of internal investigations is quite varied. The *DDRS Mandatory Components of an Investigation Policy* (http://www.in.gov/fssa/files/Mandatory_Components_of_an_Investigation.pdf) was published with an effective date of 3/16/2012.

Providers should review their own policy and practices, review a sampling of their internal investigation (e.g., does the information contained in the investigation support the outcome/result, are systemic issues identified and addressed as a result of the investigation?), ensure an unbiased person is conducting an investigation, and obtain technical assistance in this area if appropriate.

The number of allegations substantiated by each provider ranges from 0% substantiated to 100% substantiated. As noted in Table 6, allegations of neglect continue to be substantiated the highest percentage of the time with two of the three months this quarter reporting the percentage substantiated above the monthly average. While the percentage of allegations of exploitation continues to be substantiated slightly less than allegations of neglect, the number of substantiated allegations of exploitation for November 2012 is significantly higher than the substantiation rate for the other 11 months. Allegations of physical abuse continue to be substantiated the lowest percentage of the time. Low rates of substantiation may be indicative of a faulty or insufficient investigation.

Table 6. Percentage of Allegations of Abuse, Neglect, Exploitation Substantiated for People Receiving Waiver Services.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Average
Allegations of Neglect	44.29%	51.09%	47.83%	62.37%	50.32%	43.62%	59.06%	55.41%	44.44%	59.48%	45.76%	66.67%	52.53%
Allegations of Exploitation (sexual, financial, other)	44.19%	36.00%	39.13%	55.26%	48.39%	40.48%	48.28%	53.33%	44.44%	45.95%	76.47%	16.67%	45.71%
Allegations of Abuse, Emotional/Verbal	45.76%	24.29%	51.11%	35.82%	33.85%	30.59%	26.79%	42.05%	19.40%	33.80%	32.69%	26.19%	33.53%
Allegations of Abuse, Sexual	16.67%	16.67%	44.44%	27.27%	37.50%	33.33%	26.32%	25.00%	20.00%	55.56%	71.43%	36.36%	34.21%
Allegations of Abuse, Physical	14.63%	30.19%	23.26%	25.00%	31.11%	20.63%	28.89%	27.54%	25.76%	16.33%	32.56%	21.74%	24.80%

Compliance with IAC 460 regulations regarding staff suspension from duty pending the outcome of the investigation is a focus area. Table 7 provides information on the percentage of times when staff were suspended in compliance with IAC 460 regulations.

A field for noting whether the staff person was suspended from duty pending the outcome of the investigation was added to the database effective 11/1/2011. This immediate safety measure (removing the alleged perpetrator from duty to reduce risk to the alleged victim and others) should be clearly stated as part of the initial incident report, but there are times when it is not. There are other times when the initial incident report and a follow-up report(s) have a discrepancy on whether or not staff were suspended from duty.

It is encouraging to see improvement in compliance with suspending staff (when the alleged perpetrator) for allegations of abuse, neglect and exploitation. Providers continue to be reminded of this regulation as part of the incident review process and also as part of the provider review process.

Allegations of Abuse, Neglect, and Exploitation (cont.)

Table 7. Percentage of Allegations When Staff (Alleged Perpetrator) Was Suspended Pending the Outcome of the Investigation.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Aver-age
Allegations of Abuse, Emotional/Verbal	86.70%	89.40%	86.70%	88.68%	88.24%	88.89%	92.16%	88.31%	96.43%	94.74%	97.50%	96.97%	91.23%
Allegations of Abuse, Physical	60.70%	88.10%	93.10%	86.27%	93.33%	82.35%	85.71%	92.31%	95.56%	81.25%	100.0%	96.88%	87.96%
Allegations of Exploitation (sexual, financial, other)	73.90%	83.30%	85.70%	83.33%	77.78%	83.33%	93.75%	76.47%	77.78%	90.48%	63.64%	92.86%	81.86%
Allegations of Neglect	67.40%	75.90%	77.70%	87.70%	78.08%	80.88%	78.99%	83.45%	90.76%	91.59%	83.02%	90.22%	82.14%
Allegations of Abuse, Sexual	100.0%	50.00%	100.0%	75.00%	75.00%	N/A	25.00%	100.0%	100.0%	33.33%	100.0%	100.00	78.03%

An excerpt from Indiana Administrative Code 460 6-9-5 Incident reporting:

> "Sec. 5. (a) An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS: (1) Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to adult protective services or child protection services as applicable. *The provider shall suspend staff involved in an incident from duty pending investigation by the provider*."

In the event of an allegation of abuse, neglect or exploitation, the provider must take immediate action to ensure the health and welfare of both the alleged victim(s) and any other people receiving services. In the event a staff person is the alleged perpetrator, this includes suspending the staff from duty pending investigation by the provider.

In other cases, staff were not scheduled to be on duty (e.g., vacation, off shift, etc.), during the time of the investigation. Based on narrative review, other examples of situations when staff were not suspended were 1) in cases when staff other than a DSP staff person was the alleged perpetrator, 2) the consumer had a history of making false allegations, 3) a specific staff person was not identified until the investigation was concluded, and 4) the agency did not view the incident as abuse/neglect/exploitation.

Providers should review their operating procedure to ensure this requirement – suspended from duty pending the outcome of the investigation - is clearly stated and staff are trained. It is also recommended that other interested stakeholders are reminded of this requirement and the reason for it – i.e., to reduce risk.

In addition, providers need to review their operating procedure/process to ensure that all of the appropriate staff (e.g., the staff person (alleged perpetrator), anyone who schedules staff for overtime or to work in another home/location, and all appropriate supervisory/ management/human resources staff) are aware that the alleged perpetrator is not able to work overtime, work another shift, or work in another home/location until the investigation is completed.

Providers should also review their data regarding allegations of abuse, neglect, and exploitation along with the data presented in Tables 6 and 7. Are trends tracked – percentage of substantiation per type of allegation; percentage of substantiation per category of reporter (alleged victim, other consumer, staff, family member, community person); are there any variables identified as being consistent issues leading to unsubstantiation; has the agency addressed those variables?

Behavioral Failures

The state of Indiana prohibits the use of prone restraint (face down on the stomach), mechanical restraint, seclusion, and use of aversive techniques for a person receiving services through a waiver. Please reference the *DDRS Use of Restrictive Interventions Including Restraints Policy* (http://www.in.gov/fssa/files/Use_of_Restrictive_Interventions.pdf).

The teams for people who have had one of these prohibited restrictive interventions utilized should review the DDRS policy, revise their operating policy/procedure, review the behavioral support plans (BSP) for the people who were involved to ensure these interventions are not part of the BSP, and retrain staff in these areas. Three people each had one report of seclusion during the past quarter. In addition, three people were each restrained once in the prone position in the past quarter and a fourth person had a prone restraint used twice this quarter. There was one report of the use of a mechanical restraint for behavioral purposes and one report of the use of an aversive technique during this past quarter (Table 8).

The *Community Services Reporter* published by the National Association of State Directors of Developmental Disabilities Services (NASDDS) provides updates on which states prohibit the use of prone restraint and seclusion. Neighboring states that also prohibit the use of prone restraint and seclusion are Illinois, Michigan, and Ohio.

Additional information regarding the danger of utilizing a prone restraint can be found at:

- *Asphyxial Death during Prone Restraint Revisited; A report of 21 cases.* O'Halloran R, et al. The American Journal of Forensic Medicine and Pathology 21(1) March 2000;
- *National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint.* Equip for Equality – A Special Report from the Abuse Investigation Unit, 2011.

The teams for people who have had multiple restraints (e.g., manual/physical, PRN medications) utilized in the past six months should seek technical assistance on behavioral intervention strategies. This should include consultation with the Level 1 Behavioral Clinician.

Of the 19 people who were arrested during this quarter, four of them were arrested more than once.

One hundred and eighty-seven people had a report of a behavioral failure this quarter. It will be interested to see if the downward trend this quarter in the use of PRN medications for behavioral purposes continues next quarter.

Table 8. Number of Behavioral Failures Reported for People Receiving Waiver Services.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Average
Restraint, Manual/ Physical Restraint Technique - Behavioral Purposes	129	103	114	76	118	111	81	92	67	93	65	69	93.17
PRN Medication - Behavioral Purposes	81	53	77	77	79	90	95	90	84	106	81	71	82.00
Arrested	14	18	13	9	14	16	14	8	14	12	4	8	12.00
Seclusion	1	0	1	2	1	1	1	0	1	1	1	1	0.92
Restraint, prone	2	3	1	0	0	0	1	2	0	1	3	1	1.17
Restraint, Mechanical Restraint Technique - Behavioral Purposes	1	1	0	1	2	1	0	0	0	1	0	0	0.58
Use of Aversive Technique	0	0	0	0	0	1	0	0	0	1	0	0	0.17
Grand Total	228	178	206	165	214	220	192	192	166	122	89	81	171.08

Medication Errors

With the implementation of the revised *Incident Reporting and Management Policy* effective 3/1/2011 which expanded the criteria for reportable medication errors, a significant increase in reported medication errors is noted. The number of medication errors reported in December 2012 is the lowest number reported since during the past 22 months (since 2/2011).

From analysis of the types of medication errors being reported, it was noted there were incident reports being submitted indicating the person did receive a medication; however, it was given outside the window of time. In order to capture those instances, an additional coding option of *medication error, given outside window* was added 11/1/2011. Medications must be given within a half hour of the time that is listed on the medication log (Centers for Medicare & Medicaid Services [CMS] *Interpretive Guidelines*; Core A Medication Administration Training). This means that you have a half hour before the medication is due, and a half hour after it is due to administer the medication.

The category of medication error reported most frequently has remained consistent since 3/2011 – medication error-missed dose, not given (Table 9). While there have been three short bursts of downward trends in this category of medication error, the overall number is significant. The last four months of data for medication errors-wrong dose are all below the monthly average. The overall frequency of reported medication errors shows a downward trend over the past three months (October 2012 to December 2012) with two of the three months below the monthly average.

Table 9. Medication Errors Reported

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Average
Medication error, missed dose, not given	296	278	302	344	322	325	340	289	279	311	290	278	304.50
Medication error, wrong dose	84	72	69	81	67	70	72	102	64	62	69	59	72.58
Medication error, wrong medication	47	42	25	23	29	20	28	36	25	41	30	26	31.00
Medication error, given outside window	16	26	12	17	21	16	25	24	19	16	11	12	17.92
Medication error, wrong route	1	0	0	0	1	1	0	0	0	0	1	1	0.42
Grand Total	444	418	408	465	440	432	465	451	387	430	401	376	426.42

Staff who administer medication are required to be trained at least annually on a medication administration program. Additional emphasis should be placed on refresher training for those with medication administration errors, that the provider's policies/procedures are reviewed (and revised as needed), that the policies/procedures are implemented as written, and an effective and timely monitoring system for medication administration is in operation. An observation of a medication pass should be part of the provider's ongoing competency-based training program. A sample medication pass checklist is included as part of this quarterly report and communication.

On-Site Medication Assessment (OSMA)

PRINT Name: _____ Signature: _____

Observer: _____ Agency: _____

Employee must demonstrate the ability to prepare, administer and record the administration of medication by successfully completing the steps noted below. A trial is defined as a pour and pass of one medication. **Staff must complete 2 trials with 100% accuracy.**	Use the following codes to indicate performance: S = Satisfactory; U = Unsatisfactory; N/A = Not Applicable			
	/ /	/ /	/ /	/ /
Assembles appropriate equipment: Medications, med cups, water, etc.				
Uses good hand washing techniques				
Checks MAR against prescribed orders (with each new MAR)				
Selects appropriate meds for the time being given				
Compares drug labels to MAR x 3 (MAR present and used through entire med pass)				
Observes the six (6) rights of Meds Pass (Right person, Right medication, Rights dose, Right route, Right time, Right documentation)				
Observe the individual's condition for any signs of illness or altered state (e.g., drug interaction). Check for vital signs being taken (if required)				
Correctly administers medication (e.g., route, with water, food, etc.)				
Ensure meds are taken/swallowed (identify potential swallowing issue)				
Documents medication correctly on MAR before proceeding to the next person (should include initials/full signature in appropriate place, etc)				
Washes hands between Individuals				
Medications are kept in a secure location at all times				
Staff does not leave meds unattended/med pass area during med pass				
Staff locks medication area before leaving the area.				

Follow Up Questions about Medication:	/ /	/ /	/ /	/ /
Check staff knowledge of Medications (Desired effect, Potential Side effects, Side Effect monitoring)				
Check staff knowledge missed medications, medication refusals and Medication errors.				
Check staff knowledge related to use of PRN medication (i.e., documentation on back of MAR, reason for use, response and signature)				

Notes: _____

Choking Episodes Requiring Intervention

Definition: Choking is the inability to breathe because the trachea is blocked, constricted, or swollen shut. Choking is a medical emergency. When a person is choking, air cannot reach the lungs. If the airways cannot be cleared, death follows rapidly.

There have been a total of 16 deaths (all funding sources) due to asphyxiation (associated with food/pica/objects/medication/vomitus) from October 2011 through December 2012 with two of these deaths occurring this quarter. The total number of 2012 choking episodes requiring intervention for people receiving waiver services are noted in Table 10.

Table 10. Number of Choking Episodes Requiring Intervention Reported for People Receiving Waiver Services.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Average
Choking Requiring Intervention	11	8	11	11	11	11	12	10	9	10	8	8	10.00

If a person has a choking episode requiring intervention, the initial incident report, follow-up report(s), and other pertinent documentation are reviewed to determine what actions have been taken to prevent another choking episode. **What safety measures have been put in place before the next time the person eats/drinks/takes medications?** The interdisciplinary team should also identify future action(s) as a longer term remedy, but it is important to implement some immediate safety measure(s).

There have been several choking episodes requiring intervention where the person already had a choking prevention plan and still choked. In these cases, the current plan was not effective for some reason. **How did the team address the failure of the current plan?** It is possible the plan itself was fine, but the failure was due to another variable (e.g., staff were not implementing the plan correctly, the appropriate supervision was not in place, etc.). If those factors contributed to the choking episode, the immediate safety measure must address those identified variables.

People are at risk in all locations. Individual-specific choking prevention/dining plans must be available and consistently implemented in all locations (e.g., home, day program, restaurant, church events, the family home, other special events (Special Olympics), etc.) and staff/natural supports in all locations need to be trained on the current plans.

Following notification of at least one death, the following announcement was placed on the DDRS website and the link was included in e-mails sent to provider agencies and case managers when processing incident reports.

During the Thanksgiving holiday, there was at least one death related to choking while the consumer was visiting in their relatives' home. In an effort to promote the health, safety and well-being of all consumers during the holiday season, please take the time to reinforce the importance of family members/friends being knowledgeable of and implementing risk plans, especially in the area of choking prevention. This is also applicable to assuring substitute staff are knowledgeable of and can implement consumers' dining plans. It is best practice to ensure that risk plans are consistently implemented in all settings.

Some guidelines:

- Provide a written copy of the dining/choking prevention plan to any family member(s)/friend(s) that the consumer will be visiting.
- Review the plan with the family member(s)/friend(s) so that it is clearly understood.
- The dining plan and visit preparations should include, but is not limited to:
    1. The person's diet, including texture of food items (e.g., pureed, chopped ½ inch cubes, ground meat, etc), prescribed consistency of any liquid (e.g., nectar thick, honey thick, etc.), size of food items (e.g., food presented in pieces the size of a quarter, etc.), list of any food items that should be avoided (e.g., hot dogs, peanut butter, hard/firm fruit, etc.).
    2. Instructions on how to prepare the diet. If applicable, using a food processor for a pureed diet, to ensure there are no lumps; demonstrating how to make a liquid nectar thick, etc.
    3. The optimal position for eating (90 degrees upright in a chair, etc.).
    4. The optimal position after eating (remaining 90 degrees upright in a chair for 60 minutes after eating, etc.).
    5. Any behavioral precautions to ensure safety during meals/snacks/medication administration (e.g., strategies to slow down the rate of eating, reduce likelihood of talking with his/her mouth full, avoiding distraction, etc.)
    6. Explanation of the level/type of supervision needed during meals/snacks/ medication administration (e.g., sit on the

Choking Episodes Requiring Intervention (cont.)

person's right side at the table while he/she is eating, etc.)

- Caution should be taken to ensure food items not prepared in the correct texture/consistency are not available (e.g., whole rolls sitting in a basket on a kitchen counter when the person's food should be presented in quarter size pieces, leaving trash can and/or waste basket content available to the consumer, etc.)
- List of any adaptive equipment/utensils to be used to promote safe mealtime/snack time/medication administration experiences.
- Ensure the receiving family/friends have the adaptive equipment and it is in good condition.
- Ensure the receiving family member(s)/friend(s) have thickening ingredient if that is required.
- The family member(s)/friend(s) should be able to demonstrate the skill in creating the correct texture of food and correct degree of thickening, if a specialized diet is required.

A checklist of questions/probes regarding a choking episode is available on the BQIS website (http://www.in.gov/fssa/ddrs/2635.htm) and should be used by the team to address any identified variables that contributed to the choking episode. The checklist can also be utilized as a proactive risk management and educational tool for ID teams.

Additional resources include:
http://www.in.gov/fssa/files/Mortality_12.27.11.pdf
http://www.in.gov/fssa/files/Choking_Checklist.pdf
http://www.in.gov/fssa/files/Morality_Communication_7_9_12.pdf
http://www.in.gov/fssa/files/Quarterly_Report_MR_1.31.12.pdf

Emergency Room Visits and/or Hospital Admissions, Medical and Psychiatric

The number of incidents associated with ER visits has varied during the past twelve months with a monthly average of 541.17 ER visits for medical reasons (Table 11). While the reasons for an ER visit or a hospital admission can be varied, the underlying factor is that a change in status (real or perceived) was noted. A variety of fact sheets and resource materials relative to recognizing and responding to changes in health status and medical conditions/situations are available on the BQIS website (http://www.in.gov/fssa/ddrs/2635.htm). Providers should incorporate these materials into their operating policies/procedures and individual-specific risk plans and ensure staff are trained to competency.

The number of in-patient hospitalizations for medical reasons presents two upward trends - late winter/early spring (January 2012 through April 2012) and another upward trend in early summer to early fall (June 2012 through September 2012) (Table 11). Based on review of data for the past 12 months, an average of 30.94% of ER visits for medical reasons lead to hospitalizations with an upward trend noted from May 2012 through October 2012 (Table 12).

ER visits for medical reasons has presented upward trends through the months; however, there is also a downward trend noted during August through November 2012.

Both ER visits and in-patient hospitalizations for psychiatric reasons began trending upward beginning in April 2012, reached a high in July and June respectively, and then trended downward through September 2012.

Table 11. Number of ER Visits/Hospital Admissions Reported for People Receiving Waiver Services.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Average
Emergency Room Visit - Medical	512	540	557	547	587	536	563	569	558	507	495	523	541.17
In-patient Hospitaliza-	170	174	173	178	163	147	165	168	170	159	174	161	166.83
Emergency Room Visit	75	57	71	60	64	75	86	60	47	69	50	54	64.00
In-patient Hospitaliza-	44	43	45	43	46	56	42	38	29	33	28	35	40.17

Emergency Room Visits and/or Hospital Admissions (cont.)

Table 12. Number and Percentage of ER Visits Leading to In-patient Hospitalizations

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Aver-age
Number of ER Visits Leading to In-patient Hospitalizations (for medical reasons)	169	174	174	178	164	150	165	167	174	159	144	191	167.42
% of ER Visits Leading to In-patient Hospitali-zations (for medical reasons)	33.01%	32.22%	31.24%	32.54%	27.94%	27.99%	29.31%	29.35%	31.18%	31.36%	29.09%	36.52%	30.94%

Reports of falls with injury contributed the highest number of ER visits for eight of the past 12 months falling to the number two spot in April 2012 and for the entire last quarter (October through December 2012). Respiratory issues contributed the highest number of ER visits during this last quarter. While not all of ER visits due to respiratory issues resulted in a diagnosis of pneumonia, providers might be interested in the Pneumovax Recommendation section of the Mortality Communication for the time period of October 2012-December 2012 File cabinet\Quarterly Report\Mortality quarterly 1-22-13.docx. The total for the top seven reasons for ER visits contributed between 59.50%-86.19% of all ER visits with an average of 67.26%. When reviewing the information in Table 13, providers should be mindful of people who have similar issues who are receiving services through their agency. Is there an individual-specific risk plan in place? Does the risk plan have both proactive as well as reactive components? Have all of the staff received recent training on the person's individual-specific risk plan?

Table 13. Top Seven Reasons for Emergency Room Visits (for medical reasons)

Top 7 Reasons for ER Visit (medical)	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Aver-age	Total
Fall with injury	72	74	76	69	92	67	82	98	74	73	72	71	76.67	920
Nonspecific health status change	54	61	67	72	72	63	70	55	57	60	65	70	63.83	766
Respiratory issue	58	56	47	55	42	41	27	49	54	92	89	84	57.83	694
Genitourinary/Renal	42	46	48	45	43	49	45	49	51	68	45	67	49.83	598
Digestive system, upper	34	39	33	36	34	38	48	44	42	56	60	52	43.00	516
Seizure activity	42	36	35	36	52	42	40	40	32	40	31	25	37.58	451
Digestive system, lower	23	33	32	41	26	26	23	22	40	48	60	49	35.25	423
Total of top 7 Reasons for ER Visit (medical)	325	345	338	354	361	326	335	357	350	437	422	418	364.00	4368
Top 7 Reasons / Total ER Visits (medical)	63.48%	63.89%	60.68%	64.72%	61.50%	60.82%	59.50%	62.74%	62.72%	86.19%	85.25%	79.92%	67.26%	

Emergency Room Visits and/or Hospital Admissions (cont.)

If a person goes to the ER, the IDT needs to request a copy of the ER record and in the event a person is hospitalized, the IDT needs to request a copy of the hospital discharge summary and patient discharge instructions. These documents contain information that should be incorporated into existing risk plans, used to develop individual-specific risk plans (for new diagnoses), timely communicated to team members, and used for staff training purposes.

The teams for people who have had multiple ER visits and/or hospital admissions within the past three months should take a close look at the person's diagnoses, the risk plans in place, staffing levels, the home environment, and other relevant factors and have an honest discussion among the team members (including the consumer, guardian, physician, etc.) on whether the current setting can meet the person's current needs. Another option for teams to consider would be scheduling more frequent visits designed to proactively meet the person's medical needs and provide additional opportunity for health care professionals to observe and identify more minor changes to health status that a lay person may miss.

Competency-Based Training

Competency-Based Training reduces risk that an incident will occur and improves outcomes.

Staff training is an important component for successful implementation of ISPs, risk plans, behavior plans, agency policies/procedures, etc. There is currently a wide range of methodology being utilized ranging from "read and sign" to competency-based training.

Competency-based training emphasizes not only what a person **knows** at the end of the training, but how a person **uses** this knowledge. While a written test tests a person's knowledge of the subject (e.g., risk plan), it does not test the person's ability to independently perform a certain task according to the established criteria (e.g., thickening liquids to the prescribed consistency, presenting all food items in the correct texture and size, safely transferring a person using a Hoyer lift, properly using a gait belt, etc.). For a person to be assessed as competent, he/she must demonstrate the ability to perform the trained task and duties to the standards expected by the employer or trainer.

The instructor demonstrates the appropriate way to complete a task and then observes the trainee perform the same task, giving appropriate feedback and correction until the trainee is perfectly proficient. The instructor demonstrates the need for and implements an ongoing monitoring system to ensure continued competency. The instructor verifies competency for each skill annually or more frequently if indicated. Ideally, competency-based training would be completed any time a risk plan is developed and/or revised.

Written tests which try to assess physical skills are not effective because people can often repeat the steps to a task, but may actually perform the task differently than they explain it.

The best way to learn a skill that requires hands-on performance and thus prevent a "skills gap" is to provide hands-on training with sufficient practice and feedback to assure the trainee knows what is expected and can perform the skill with complete proficiency.

Competency-based training decreases confusion, empowers staff to know when and how to provide appropriate interventions, and decreases the consumer's apprehension when a less familiar staff is working with him/her.

Competency-based training also demonstrates to everyone involved that an intervention completed in a particular way can be done, is effective when implemented, that needed supplies are available, and that needed equipment is present and functioning correctly.

Being trained to competency for a particular task does not mean the person can train others on the task.

Presenting the idea in a table format clarifies the idea of competency-based training. The corresponding competencies are all some type of action (e.g., conduct, complete, develop, etc.) to be performed by the trainee and assessed by a person

Competency-Based Training (cont.)

If the table format is used for a couple of risk plans (the bird's eye view), it might look something like this:

Curriculum Topic Area	Corresponding Competencies
Risk plan for someone on a honey thickened liquid	Thicken liquid to specified consistency – honey (follow all steps to be taken at mealtime (at home or in community), snack time, medication administration).
Risk plan for someone on a pureed diet	1. Prepare food items to specified consistency (pureed). 2. Demonstrate how to check to ensure the food item is the correct consistency. 3. Identify any food items that should not given to the person because of the diet texture. 4. Follow all steps to be taken at mealtime (at home or in community), snack time, medication administration)
Risk plan for someone who eats too fast	Depending on the techniques described in the specific risk plan being trained – some examples include: 1. Demonstrate technique to present food using the plate-to-plate method. 2. Demonstrate verbal prompts to slow down (e.g., John, please put your fork down while you chew). 3. Demonstrate physical prompt to slow down (e.g., hand over hand assistance to put the fork down). 4. Demonstrate verbal prompt for John to take a sip of liquid every two bites.
Mobility (for a person with a gait belt)	1. Use gait belt as specifically noted in risk plan (e.g., ambulating on level surfaces, uneven surfaces, rising from seated position, when transferring, etc.). 2. Be able to state when the gait belt should be used (e.g., 24/7, long distances (and what that means for the specific person), etc.). 3. Put the gait belt on. 4. Remove the gait belt. 5. Check the condition of the gait belt (e.g., cleanliness, excess wear (fray, broken buckle, etc.) and document per agency policy/procedure.

A couple of examples of competency-based training assessments (CBTAs) for thickened liquids and use of a gait belt along with the respective training protocols are available at the following links - Generated reports - temporary holding\cbta honey thick liquids.docGenerated reports - temporary holding\Training Protocol for thickening liquids.docGenerated reports - temporary holding\cbta one person walking with narrow gait belt.docGenerated reports - temporary holding\Training Protocol one person walking with person wearing gait belt.doc.

Relevant References/Resources:

- The DDRS policy regarding DSP training - http://www.in.gov/fssa/files/Requirements_Training_of_Direct_Support_Professional_Staff.pdf
- There are some good resources on the BQIS.IN.GOV website regarding competency-based training and related checklists. A few of these include:
    1. http://www.in.gov/fssa/files/competency_based_training.pdf
    2. http://www.in.gov/fssa/files/reminder_-_WC_staff_training.pdf
    3. http://www.in.gov/fssa/files/AST_Positioning_Competency-Based_training_checklist_OR-FM-AS-PS-71(11-10-09).pdf
    4. http://www.in.gov/fssa/files/Dysphagia_Competency_based_training_checklist_OR-FN-HS-DY-26(11-9-09).pdf
    5. http://www.in.gov/fssa/files/Competency_based_Instructions_OR-FN-HS-MS-17(11-9-09).pdf
    6. http://www.in.gov/fssa/files/Mealtime_Competency-Based_Training_Checklist_OR-FN-HS-MS-38(11-9-09).pdf
    7. http://www.in.gov/fssa/files/Oral_Care_and_Med_Pass_Competency-Based_training_checklist_OR-FN-HS-MS-44(11-9-09).pdf
- The Quality Mall, an organization that provides person-centered services supporting people with developmental disabilities - http://www.qualitymall.org/products/prod5.asp?prodid=322

Competency-Based Training (cont.)

- American Society for Training and Development (ASTD) website - http://www.astd.org. They also have a book about competency-based training - http://www.amazon.com/Competency-Based-Training-Basics-ASTD/dp/1562866982.
- National Alliance for Direct Support Professionals (NADSP) - https://www.nadsp.org/2011-09-22-14-00-06.html.
- The Direct Service Workforce Resource Center has numerous resources on Health Support - http://www.dswresourcecenter.org.

Resources Regarding Incident Reporting and Management

The link to the DDRS Incident Reporting and Management Policy is http://www.in.gov/fssa/files/Incident_Reporting_and_Management_3-1-11.pdf.

In addition, the link to the Frequently Asked Questions (FAQs) relative to Incident Reporting is http://www.in.gov/fssa/files/FREQUENTLY_ASKED_QUESTIONS_TABLE_OF_CONTENTS_3-8-11.pdf.

Additional information related to specific topics (e.g., Pneumovax Recommendations, Familiarity with the Acute Care Hospital Nursing Administration, etc.) are available in the Mortality Data and Recommendations found on the BQIS.in.gov website.